

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4163HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2009
NAME OF PROVIDER OR SUPPLIER RED ROCK BEHAVIORAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 5975 W TWAIN AVE LAS VEGAS, NV 89103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of a complaint survey conducted in your facility on 3/26/09.</p> <p>The census at the time of the survey was 19.</p> <p>The survey was conducted using the authority of NAC 449, Hospitals, last adopted by the State Board of Health on August 04, 2004.</p> <p>Complaints Investigated:</p> <p>Complaint #NV00021342 - Unsubstantiated Complaint #NV00020800 - Unsubstantiated</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>There were no regulatory deficiencies identified.</p>	S 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE